Post-COVID-19 condition (long COVID)

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REPORTING INFORMATION
(To be completed by the CPSP)
Report number:
Month of reporting:
Province:
Today's date:

Please complete the following sections for the case identified above. If the information requested below is not readily available, please leave it blank. Strict confidentiality of information will be assured.

CASE DEFINITION FOR POST-COVID-19 CONDITION (LONG COVID)

Report any patient less than 18 years of age (up to the 18th birthday) who meets both of the following criteria:

1) Experiencing one or more new or persistent symptoms after recovery from acute COVID-19 (acute COVID-19 proven by laboratory testing and/or highly suspected based on clinical history)

AND

2) Symptoms have persisted for at least eight (8) weeks

SECTION 1 – PATIENT DEMOGRAPHIC INFORMATION

1.1 Month/year of birth: ____ /_____
MM YYYY

1.2 Sex assigned at birth: ❍ Male ❍ Female ❍ Intersex

1.3 First 3 digits of patient's postal code: ___ ___ ___

1.4 Patient- or family-reported population group(s) (select all that apply):

- ❑ Arab
- ❑ Black
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Latin American
- ❑ White
- ❑ First Nations
- ❑ Inuit
- ❑ Métis
- ❑ Unknown/Did not ask
- ❑ Southeast Asian (e.g., Vietnamese, Cambodian, Laotian)
- ❑ South Asian (e.g., East Indian, Pakistani, Sri Lankan)
- ❑ West Asian (e.g., Iranian, Afghan)
- ❑ Other, specify: _____

SECTION 2 – CO-MORBIDITIES

2.1 Does this patient have any chronic co-morbid conditions that predate the acute COVID-19 diagnosis?
❍ Yes ❍ No ❍ Unknown
If Yes, select all that apply:

❑ Asthma ❍ Not requiring daily controller medication ❍ Requiring daily controller medication ❑ Eczema ❑ Seasonal or environmental allergies ❑ Depression ❑ Anxiety ❑ Other mental health condition (either active or resolved), specify:_____ ❑ Migraines or chronic headaches	❑ Obesity Indicate height _____cm and weight _____kg ❑ Diabetes mellitus (DM) ❍ Type 1 DM ❍ Type 2 DM ❑ Other, specify: _____ _____

SECTION 3 – COVID-19 VACCINATION

3.1 Has this patient received any COVID-19 vaccinations? ❍ Yes ❍ No ❍ Unknown

If No: **Proceed to question 4.1**

If Yes: 3.1.1 Number of doses: ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ Unknown

3.1.2 Date of first vaccination: ____ /____ /_____ ❍ Unknown
DD MM YYYY

3.1.3 Date of second vaccination: ____ /____ /_____ ❍ Unknown ❍ Patient did not receive a second dose
DD MM YYYY

3.1.4 Date of third vaccination: ____ /____ /_____ (DD / MM / YYYY) ❍ Unknown ❍ Patient did not receive a third dose

3.1.5 Date of fourth vaccination: ____ /____ /_____ (DD / MM / YYYY) ❍ Unknown ❍ Patient did not receive a fourth dose

3.1.6 Were any doses of COVID-19 vaccine given after the onset of long COVID symptoms?

❍ Yes ❍ No ❍ Unknown

3.1.6.1 *If Yes,* what was the patient/family's perception of the effect of COVID-19 vaccination on their long COVID symptoms? ❍ Improved symptoms ❍ Worsened symptoms ❍ No effect on symptoms ❍ Patient/family unsure/don't know ❍ Unknown to the reporting physician

SECTION 4 – DETAILS OF ACUTE COVID-19 ILLNESS

4.1 Has the patient had acute COVID-19 more than once? ❍ Yes ❍ No ❍ Unknown

4.1.1 *If Yes,* how many times has the patient had confirmed or highly suspected acute COVID-19? _____

Note: If the patient has had confirmed or highly suspected acute COVID-19 more than once, please complete the following questions based on the episode that occurred closest in time AND prior to the onset of the long COVID symptoms.

4.2 Date of acute COVID-19 symptom onset: ____ /_____ (MM / YYYY) ❍ Unknown ❍ Asymptomatic

4.3 Was microbiologic testing done to diagnose COVID-19? ❍ Yes ❍ No ❍ Unknown

4.3.1 *If Yes*, complete a column in the following table for each test result available:

Date	____ /____ /_____ (DD / MM / YYYY)	____ /____ /_____ (DD / MM / YYYY)	____ /____ /_____ (DD / MM / YYYY)
Test	❍ Polymerase chain reaction ❍ Rapid antigen ❍ Serology ❍ Unknown ❍ Other, specify: _____	❍ Polymerase chain reaction ❍ Rapid antigen ❍ Serology ❍ Unknown ❍ Other, specify: _____	❍ Polymerase chain reaction ❍ Rapid antigen ❍ Serology ❍ Unknown ❍ Other, specify: _____
Result	❍ Positive ❍ Negative ❍ Indeterminate ❍ Unknown	❍ Positive ❍ Negative ❍ Indeterminate ❍ Unknown	❍ Positive ❍ Negative ❍ Indeterminate ❍ Unknown

4.3.2 *If No,* was the diagnosis of acute COVID-19 made by clinical history alone? ❍ Yes ❍ No ❍ Unknown

4.3.2.1 *If Yes,* did the patient have a known COVID-19 contact?

❍ Known contact with person with confirmed COVID-19?

❍ Known contact with person with probable COVID-19?

❍ No known contact

❍ Contact history unknown

4.4 Highest level of care required during acute COVID-19 illness:

❍ Managed at home ❍ Outpatient/Emergency room visit ❍ Inpatient ward ❍ Intensive care unit ❍ Unknown

4.5 Did the patient experience any serious complications during the acute phase of the illness (e.g., pneumonia, acute respiratory distress syndrome, acute necrotizing encephalitis, bacterial sepsis, fungal infection)?

❍ Yes ❍ No ❍ Unknown

4.5.1 *If Yes,* specify: _____

4.6 Did the patient require hospitalization for multisystem inflammatory syndrome in children (MIS-C)/paediatric inflammatory multisystem syndrome (PIMS)/post-infectious hyperinflammatory syndrome? ❍ Yes ❍ No ❍ Unknown

4.6.1 *If Yes*, what was the date of MIS-C/PIMS/post-infectious hyperinflammatory syndrome symptom onset?

____ /_____ (MM / YYYY) ❍ Unknown

SECTION 5 – DETAILS OF PERSISTENT SYMPTOMS FOLLOWING ACUTE COVID-19

5.1 Date of initial encounter with reporting physician for long COVID: ____ /_____
MM YYYY

5.2 Date of onset of first long COVID symptom: ____ /_____ ❍ Unknown
MM YYYY

5.3 Period of time between resolution of acute COVID-19 symptoms and onset of first long COVID symptoms:
❍ Zero days (i.e., no period of feeling well between acute COVID-19 and development of long COVID symptoms)
❍ < 1 week ❍ 1–2 weeks ❍ 2–4 weeks ❍ > 4 weeks ❍ Unknown

5.4 Indicate which persistent symptoms the patient experienced following acute COVID-19 by completing the following information for each symptom experienced:

Symptom	**New since acute COVID-19**	**Was present before acute COVID-19, but worse now**	**At the time of clinical encounter, the symptom was:** **Stable**	**Fluctuating**	**Worsening**	**Improving**	**Resolved**
Fever	❍	❍	❍	❍	❍	❍	❍
Lightheadedness or syncope	❍	❍	❍	❍	❍	❍	❍
Rash	❍	❍	❍	❍	❍	❍	❍
Hair loss	❍	❍	❍	❍	❍	❍	❍
Loss or altered sense of taste/smell	❍	❍	❍	❍	❍	❍	❍
Rhinitis or sinusitis	❍	❍	❍	❍	❍	❍	❍
Cough	❍	❍	❍	❍	❍	❍	❍
Shortness of breath	❍	❍	❍	❍	❍	❍	❍
Chest pain or tightness	❍	❍	❍	❍	❍	❍	❍
Palpitations	❍	❍	❍	❍	❍	❍	❍
Nausea	❍	❍	❍	❍	❍	❍	❍
Vomiting	❍	❍	❍	❍	❍	❍	❍
Diarrhea	❍	❍	❍	❍	❍	❍	❍
Constipation	❍	❍	❍	❍	❍	❍	❍
Abdominal pain	❍	❍	❍	❍	❍	❍	❍
Abdominal bloating	❍	❍	❍	❍	❍	❍	❍
Loss of appetite	❍	❍	❍	❍	❍	❍	❍
Arthralgia	❍	❍	❍	❍	❍	❍	❍
Myalgia	❍	❍	❍	❍	❍	❍	❍
Headache	❍	❍	❍	❍	❍	❍	❍
Sleep disturbance	❍	❍	❍	❍	❍	❍	❍
Anxiety	❍	❍	❍	❍	❍	❍	❍
Depression	❍	❍	❍	❍	❍	❍	❍
Cognitive symptoms ('brain fog') e.g., slow processing or difficulty with memory, attention, word finding	❍	❍	❍	❍	❍	❍	❍
Fatigue	❍	❍	❍	❍	❍	❍	❍
If fatigue present, is post-exertional fatigue experienced?			❍ Yes	❍ No			
Other, specify: _____ _____	❍	❍	❍	❍	❍	❍	❍

Other, specify: _____ _____	❍	❍	❍	❍	❍	❍	❍

5.5 Did the patient/family report any of the following as attributable to the persistent symptoms?

	Yes	No	Unknown
Negative impact on school performance	❍	❍	❍
Decreased involvement in physical activities (e.g., dance classes, sports, active outdoor play)	❍	❍	❍
Decreased involvement in social activities	❍	❍	❍
Feelings of distress in the patient	❍	❍	❍
Feelings of distress in the patient's family members	❍	❍	❍
Decrease in ability to perform self-care activities (e.g., dressing, bathing)	❍	❍	❍

Other, specify:_____

5.6 Do any of the patient's family members have, or have they had, long COVID? ❍ Yes ❍ No ❍ Unknown
If Yes, specify the relationship(s) to patient (select all that apply):
❑ Parent ❑ Sibling ❑ Grandparent ❑ Other, specify: _____

5.7 Treatments, management strategies, or referrals made after initial assessment by reporting physician (select all that apply):

- ❑ Medications (e.g., antihistamines, inhalers, steroids, melatonin, pain medicine, antipyretic, salt pills)
- ❑ Rehabilitation (e.g., physiotherapy, occupational therapy, exercise program)
- ❑ Sleep hygiene measures (e.g., implementing sleeping schedule and nighttime routine, replacing daytime naps)
- ❑ Psychological and/or mental health support
- ❑ Referrals to other specialists, specify _____
- ❑ Adjustments in school programming
- ❑ Other, specify: _____

5.8 Based on the reporting physician's clinical assessment, how likely is it that the patient's persistent symptoms are related to the episode of acute COVID-19? ❍ Definite ❍ Probable ❍ Possible ❍ Unlikely

SECTION 6 – FURTHER INFORMATION

6.1 Are you willing to be contacted by the Canadian Paediatric Surveillance Program (CPSP) for further information on this questionnaire? ❍ Yes ❍ No

6.2 Are you willing to be contacted about a separate study, outside of the CPSP process, that may be conducted to better understand the long-term impact and epidemiology of long COVID in children and youth? *If yes, you agree to the CPSP releasing your contact information to the study team (led by Dr. Anu Wadhwa) for potential follow-up*
❍ Yes ❍ No

SECTION 7 – REPORTING PHYSICIAN

First name_____Surname_____

Address_____

City_____Province/territory_____ Postal code_____

Telephone number_____ Fax number_____

E-mail_____ Date completed_____

Thank you for completing this form.

(LONG COVID 2022/09)